HEALTHY WISCONSIN COUNCIL
GLOSSARY OF TERMS

Adverse selection occurs when a disproportionate share of people who apply for health insurance suspect that they have medical problems that will require expensive medical care in the near future. More generous coverage plans usually attract those individuals most in need of care.

Aggregate stop-loss is a form of reinsurance. It protects the original insurer from very large aggregate (total) losses from a book of business, or all the policies sold to a large group. The reinsurance goes into effect when total losses exceed the threshold known as stop loss. (Stop loss is equivalent to a deductible.)

Attachment points are thresholds at which reinsurance coverage goes into effect.

COBRA: Federal legislation that lets workers, who work for an insured employer group of 20 or more employees, continue to purchase health insurance for up to 18 months if they lose their job or coverage is otherwise terminated. Full name is "Consolidated Omnibus Budget Reconciliation Act."

Co-Insurance: Co-insurance refers to money that an individual is required to pay for services, after a deductible has been paid. In some health care plans, co-insurance is called "co-payment." Co-insurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

Community Rating: A regulation requiring insurers to charge all applicants the same premium for the same coverage regardless of age or health. Premiums are based on the rate determined by the geographic region's health and demographic profile. Some states allow modified community rating, that is rates can be modified by factors such as age, sex, and smaller geographic areas of residence.

Co-Payment: Co-payment is a predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HMOs require a $10 "co-payment" for each office visit, regardless of the type or level of services provided during the visit. Co-payments are not usually specified by percentages.

Deductible: The amount an individual must pay for health care expenses before insurance (or a self-insured company) covers the costs. Often, insurance plans are based on yearly deductible amounts.

ERISA refers to the Employee Retirement Income Security Act of 1974, which established federal regulations for certain employer-provided benefits, mainly pensions and health insurance coverage. The federal legislation preempts the ability of states to directly regulate employer provided benefits covered by ERISA. One of the goals of the legislation was to provide national regulation for employer plans to ensure the plans would be administered consistently, without interference from various state regulations.

Excess of loss is a form of reinsurance. The arrangement is created on a per-policy basis for an entire group or book of business. This type of reinsurance is designed to protect the original insurer from very large losses that might occur with separate policies. The reinsurance goes into effect once any individual has expenses above the agreed threshold.

HIPAA: A Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care. Full name is "The Health Insurance Portability and Accountability Act of 1996."

Indemnity Health Plan: Indemnity health insurance plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs, IPAs, and PPOs. With indemnity plans, the individual pays a pre-determined percentage of the cost of health care services, and the insurance company (or self-insured employer) pays the other percentage. For example, an individual might pay 20 percent for services and the insurance company pays 80 percent. The fees for services are defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose their health care professionals.

Guaranteed issue: a regulation requiring insurers in the individual market to accept all applicants so that an insurer cannot turn down an applicant it views as high risk.

Loss-Ratio: Percentage of each premium dollar an insurer spends on claims.

Moral hazard: In the health services literature, moral hazard is commonly used to express the additional quantity of health care demanded, resulting from a decrease in the net price of care attributable to insurance.

Reinsurance: Insurance bought by insurers. A reinsurer assumes part of the risk and part of the premium originally taken by the insurer, known as the primary company. Reinsurance effectively increases an insurer's capital and therefore its capacity to sell more coverage. Reinsurers have their own reinsurers, called retrocessionaires. Reinsurers don't pay policyholder claims. Instead, they reimburse insurers for claims paid.

Underwriter: The company that assumes responsibility for the risk, issues insurance policies and receives premiums.

Underwriting: It is sometimes called experience rating. The underwriting is a process by which insurers set the premium for an applicant based on that person's expected medical care costs. Thus, if a person has a poor health status, actuarial underwriting practices would yield a higher premium than for a similar person in excellent health. Similarly, when premiums are set for policy renewals, underwriting can yield high premiums for people who have had high medical expenses in the past six or twelve months. States may regulate underwriting practices by establishing community rating or guaranteed issue regulations.

Sources:
1. S. Folland, A. Goodman, M. Stano, "The Economics of Health and Health Care" 4th ed., 2004
2. K. Swartz, "Reinsuring Health: Why More Middle Class People are Uninsured and What Government Can Do," New York, 2006.
3. http://www.healthinsurance.org/